

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis, Mo.* (No., Sanitarium.....) Ward.....

Registration District No. **791**
Primary Registration District No. **1603**

File No.
Registered No. **27120**
St. Ward.....

2. FULL NAME

(a) Residence, No. *2610 Bellvue St.*, *11* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *68* yrs. *4* mos. *4* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Frances Bailey*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Mar. 18, 1866*

7. AGE YEARS *68* MONTHS *4* DAYS *4* If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Laborer*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Unknown*
10. Date deceased last worked at this occupation (month and year) *Unknown* 11. Total time (years) spent in this occupation *Unknown*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis, Missouri*

13. NAME *Jacob Bailey*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

15. MAIDEN NAME *Mahala*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT *Dr. Muller* (ADDRESS) *5400 Arsenal*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington, D.C.* DATE *July 26, 1934*

19. UNDERTAKER (ADDRESS) *4107 Franklin*

20. FILED *21* 19 *34* Registrar *J. H. Fredrick*

3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-22, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *10-20*, 193*0* to *7-22*, 193*4*

I last saw him alive on *7-21*, 193*4*. Death is said to have occurred on the date stated above, at *12:05* A. M.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Date of onset *10-20-30*
General Paralysis of Insane *+*

Other contributory causes of importance:

General Paralysis of Insane *10-20-30*
+

Name of operation..... Date of.....
What test confirmed diagnosis? *Chronic* Was there an autopsy? *laboratory*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

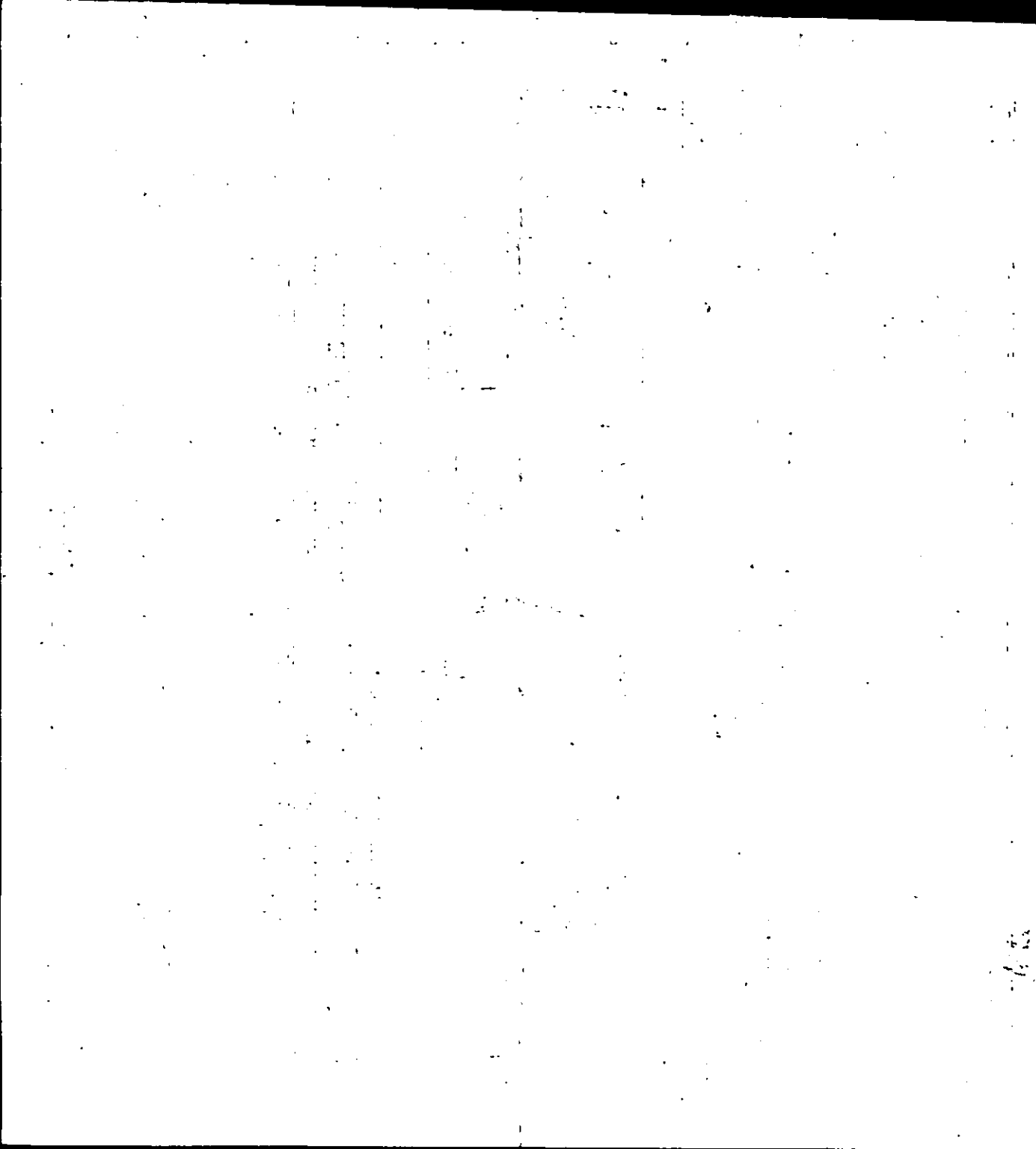
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify..... (Signed) *Dr. Muller*, M. D.
(Address) *5400 Arsenal*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 15 1934



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003
(No. *Sanitarium*)

File No. 27120
Registered No. 7357
St. Ward)

2. FULL NAME

(a) Residence, No. St. Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *B.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *m*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS *68* MONTHS *4* DAYS *4* If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED *12-14-1934* *J. F. Bredich* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 22, 1934*

22. I HEREBY CERTIFY, That I attended deceased from to

I last saw him alive on, 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Chronic pericarditis Date of onset *10-20-33*

Other contributory causes of importance: *Coronary atherosclerosis of Ins.* *(Lues.)* *10-20-34*

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify
(Signed) *W. H. McCreary* M.D.
(Address) *342 N. 1st St.*

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Q21120